

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/28/2011  
FORM APPROVED  
OMB NO. 0938-0391

450 3, 3/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445112	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/27/2011
NAME OF PROVIDER OR SUPPLIER  TREVCCA HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 329 MURFREESBORO RD NASHVILLE, TN 37210		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of facility policy, review of facility investigation, review of personnel time records, and interview, the facility failed to prevent further potential abuse during the investigation of an allegation of abuse of one resident (#34) of thirty four residents reviewed and based on interview the facility failed to report the allegation of abuse to the State.</p> <p>The findings included:</p> <p>Observation on January 25, 2011, at 9:50 a.m., revealed resident #34 in a wheelchair in the resident's room. Interview and observation at that time with the resident revealed the resident was alert, oriented, and friendly; and stated had been a resident in the facility for many years and was very pleased with the care received at the facility.</p> <p>Interview on January 26, 2011, at 2:00 p.m., with a family member of resident #34, revealed a staff member had called resident #34 a "son of a bitch."</p> <p>Review of the facility investigation revealed a handwritten note dated September 15, 2010 written by Certified Nursing Technician (CNT #6) which described an observation of resident #34</p>	F 226	<p>F226</p> <p>The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>The allegation of verbal abuse of resident #34 was fully investigated on September 15, 2010, the same date it was reported. All witnesses that were associated with the verbal abuse allegation were interviewed thoroughly and verbal statements were taken on September 15, 2010. It was determined to be unsubstantiated within 30 minutes of the allegation based on interview findings from the witnesses present during the alleged abuse. Resident #34 was mildly confused September 14 and 15 and was found to have an UTI. The incident in question involved another confused resident that called RS#1 a "SOB". This was witnessed in the Physical Therapy gym by all the therapy staff and resident #34.</p> <p>All Department Heads and staff have been inserviced regarding the abuse policy. All employees accused of participating in alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended without pay until the findings of the investigation have been reviewed by the Administrator. Those involved with and witness to the alleged abuse will write statements immediately including their signature and date. The reassigned duties and/or suspension will ensure the facility will prevent potential abuse during the investigation. (See attachment #1)</p> <p>All allegations of abuse will be reported immediately to the Administrator and/or designee. The Administrator/designee will direct the investigation to ensure that all the appropriate department heads are acting within the policy guidelines. The Administrator will monitor the investigation daily until resolution. The Administrator or Director of Nursing will report any allegation of abuse to the State. All allegations will be brought to the Quality Improvement Committee on a quarterly basis to ensure compliance with the policy and prevention of abuse to the residents.</p>	<p>Completion Date: March 13, 2011</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Man Giff* Administrator

2/9/11

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	<p>Continued From page 1</p> <p>as "acting down" (depressed) when taken to the therapy department. The note read, "Several of us asked in PT (Physical Therapy) what was wrong. (Patient #34) stated that someone had been cursing (patient #34). We asked who but...would not tell us. I went to (unit manager #3) and asked (unit manager #3) to go speak with (resident #34)."</p> <p>Review of the facility investigation revealed the Unit Manager #3 (UM #3) signed a form titled "Grievance/Concern Report" and dated it September 15, 2010 which read patient #34 stated a rehab (rehabilitation) staff had called the resident a "SOB."</p> <p>Review of the report revealed the Director of Nursing (DON) dated the grievance/concern as resolved on September 20, 2010.</p> <p>Review of the facility investigation revealed a statement by the named rehab staff (RS #1) which read, "I categorically Deny any supposed statements I made toward anyone that would portray me in a negative or unprofessional manner..." The statement by RS #1 was signed and not dated.</p> <p>Review of the facility investigation included two witness statements by Physical Therapists; one was handwritten and one was typed, and both were dated September 20, 2010. Both statements did not support the allegation of verbal abuse.</p>	F 226			
	<p>Review of the facility investigation revealed a physician's order dated September 20, 2010 received from the Geriatric Nurse Practitioner for a urine dip test for resident #34. (The order</p>				

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F 226	<p>Continued From page 2</p> <p>included to send the urine for culture and sensitivity if positive. Medical record review revealed antibiotics were started on September 20, 2010 for the treatment of a urinary tract infection.)</p> <p>Review of the facility investigation revealed a handwritten Social Services Note dated September 20, 2010 and signed by the Director of Social Services which read, "Social Services spoke (with) resident 9/20/10 regarding situation reported earlier to DON."</p> <p>Review of the investigation revealed a summation note signed by the Director of Nursing and dated September 20, 2010 that the allegation of abuse was resolved and not substantiated.</p> <p>Interview in the conference room on January 27, 2011 at 12:05 p.m., revealed the CNT #6 informed UM #3 of the observation and concerns of verbal abuse "before lunch" on September 15, 2010.</p> <p>Interview in the conference room with the UM #3 on January 27, 2011 at 12:05 p.m., revealed resident #34 was interviewed "after lunch" on September 15, 2010.</p> <p>Review of the Time Detail (actual hours worked by an employee) revealed RS #1 was on duty as usual schedule on September 15, 16, 17, and 20, 2010 and completed a regularly scheduled day, reporting in on or before 9:00 a.m., and clocking out varying from 4:03-5:17 p.m.</p> <p>Interview in the conference room on January 27, 2011 at 8:55 a.m., revealed rehab staff #1 was informed "by a tech (a certified nursing tech) a</p>	F 226			

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F 226	Continued From page 3  few days later" (after 9/15/10) that the resident #34 had reported the verbal abuse and named RS #1. Continued interview revealed RS #1 continued to work September 15-20, 2010 as scheduled providing direct patient care as usual with the exception of instruction not to care for resident #34 without supervision. Continued interview verified RS #1 did continue to provide direct patient care to residents during the investigation of the allegation of abuse; was not reassigned other duties; and was not removed from providing patient care.  Review of the facility policy titled Abuse Policy and Procedures (there is no date or number on the policy) under section Protection of Residents During Abuse Investigations reads, "Employees accused of participating in the alleged abuse will be immediately reassigned to duties that do not involve resident contact or will be suspended without pay until the findings of the investigation have been reviewed by the Administrator..."  Interview with the Director of Social Services (who is designated as the Abuse Coordinator) in the Social Services office on January 27, 2011 at 10:45 a.m., verified RS #1 was not removed from providing direct patient care or reassigned during the investigation; confirmed the facility policy was not followed; and confirmed the facility failed to prevent further potential abuse during the investigation of the allegation of abuse.  Interview with the Director of Nursing and Administrator in the Administrator's office on January 27, 2011 at 12:35 p.m., confirmed the allegation of verbal abuse was not reported to the State.	F 226			
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312	F 312	See page 5	Completion Date: March 13, 2011

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F 312 SS=D	<p>Continued From page 4 DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy and procedure review, and interview, the facility failed to provide nail care for two residents (#5, #10) of thirty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on February 2, 2009 with diagnoses including Multiple Sclerosis, Quadriplegia, and Adult Failure to Thrive.</p> <p>Medical record review of the Minimum Data Set (MDS) dated November 23, 2011 revealed the resident required assistance with all activities of daily living.</p> <p>Observation and interview with Registered Nurse (RN) #1 on January 26, 2011 at 4:25 p.m., in the resident's room revealed the resident had long toenails on both feet. Continued observation revealed all five toenails on the left foot were 1/4 - 1/2 centimeter (cm) long. Continued observation revealed the right foot fifth toenail had a sharp edge and the remaining four toenails were 1/4 - 1/2 cm long. Interview with RN #1 at that time confirmed the toenails needed to be trimmed.</p>	F 312	<p>F 312</p> <p>The facility will provide the necessary services to maintain good nutrition, grooming, and personal and oral hygiene to all residents.</p> <p>The fingernails and toenails of Resident #5 were cleaned and trimmed immediately on January 26, 2011. A Podiatry consult was ordered at that time. The consent was signed and the resident was placed on the podiatry list.</p> <p>The fingernails and toenails of Resident #10 were cleaned and trimmed immediately on January 27, 2011.</p> <p>CNT #3 was inserviced on 1/27/11 regarding preparing the residents for a meal, including washing their hands and face. (See attachment #2)</p> <p>All Nursing staff will be inserviced on the importance of weekly and PRN nail care of the fingernails and toenails. The inservice will also include preparing the resident for all meals. (See attachment #3)</p> <p>Nail care will be given at least weekly and as needed. If the resident is a diabetic toenails will be trimmed by the licensed nurse. Refusal of nail care by the resident will be documented in the record. Refusal will be reported to the Nurse Manager. The Nurse Manager will then talk with the resident and/or family concerning non-compliance with routine nail care.</p> <p>The Director of Nursing and Nurse Managers will spot check daily for compliance with nail care and meal preparation. The Director of Nursing will report their findings to the Quality Improvement Committee on a quarterly basis. The Administrator will spot check daily when making rounds to ensure compliance.</p>	<p>Completion Date: March 13, 2011</p>	

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F 312	Continued From page 5  Interview with resident #5 on January 26, 2011 at 4:30 p.m., in the resident's room revealed the resident had requested the toenails to be trimmed the week prior.  Resident #10 was re-admitted to the facility on December 10, 2010 with diagnoses including Diabetes Mellitus, Chronic Pain, and Left Above the Knee Amputation.  Medical record review of the MDS dated January 24, 2011 revealed the resident required assistance with all activities of daily living.  Observation on January 25, 2011 at 9:45 a.m., and on January 26, 2011 at 8:25 a.m., in the resident's room revealed the resident with dark debris under the tips of the fingernail .  Observation on January 27, 2011 at 7:35 a.m., in the resident's room revealed Certified Nursing Technician (CNT) #3 assisted the resident to prepare for breakfast; washed the resident's face with a wet washcloth but did not wash the resident's hands.  Observation on January 27, 2011, at 7:50 a.m., in the resident's room revealed the resident ate a piece of boiled egg with the un-washed hands.  Observation on January 27, 2010, at 8:05 a.m., with the Licensed Practical Nurse (LPN) Weekend Supervisor, in the resident's room revealed the resident with dark debris under the tips of the finger nails , and in the cuticles. Continued observation of the resident's right foot revealed all five toenails were 1- 1.5 cm long and	F 312			

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F 312	Continued From page 6 three were curled under.  Review of the facility's Policy 007 Foot and Nail Care revealed "...Nail care will be given at least weekly and as needed...If the resident is diabetic, toenails will be trimmed by the licensed nurse..."  Interview with the LPN Weekend Supervisor on January 27, 2011 at 8:08 a.m., in the resident's room revealed the resident frequently refused to allow the Podiatrist to trim the toenails. Continued interview confirmed the resident's fingernails were in need of cleaning.  Observation and interview with the LPN Weekend Supervisor on January 27, 2011 at 9:25 a.m., in the resident's room confirmed the resident's right foot toenails had been trimmed by the nursing staff.	F 312			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to provide perineal/catheter care in a	F 315	F315 The facility will provide perineal/catheter care in a sanitary manner for all residents.  Peri-Care/Foley Catheter Care education was provided to CNA #1 and CNA #2 immediately on January 27, 2011. (See attachment #4)  The remaining nursing staff will be inserviced regarding Peri-Care/Foley Catheter Care by the Infection Control Nurse (See Attachment #5)  Peri-Care/Foley Catheter Care surveillance will be completed by the Infection Control Nurse immediately after inservices completed. Infection Control Nurse will observe 10 opportunities per week.  A report of the results of observation will be compiled on a monthly basis and presented to Nurse Managers and DON by the Infection Control Nurse. The Quality Improvement Committee and Administrator will review the report quarterly and make recommendation for corrective action and for continued monitoring.		Completion Date: March 13, 2011

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F 315	<p>Continued From page 7</p> <p>sanitary manner for one resident (#5) of thirty-four residents reviewed.</p> <p>The findings included:</p> <p>Resident #5 was admitted to the facility on February 2, 2009 with diagnoses including Multiple Sclerosis, Quadriplegia, History of a Urinary Tract Infection (required hospitalization), and Adult Failure to Thrive.</p> <p>Medical record review of the Minimum Data Set (MDS) dated November 23, 2011 revealed the resident required assistance with all activities of daily living and required a urinary catheter.</p> <p>Observation on January 26, 2011 at 4:00 p.m., in the resident's room revealed Certified Nursing Technician (CNT) #1 and CNT #2 provided the resident with a bed bath. Continued observation revealed the resident had a small amount of feces in the anal area; CNT #2 wet the washcloth with water from a basin; washed the anal area and tip of the penis/catheter in a back and forth motion with the feces contaminated wash cloth four times.</p> <p>Review of the facility's Foley Catheter Care policy revealed "...The catheter will be cleaned using soap and warm water or periwash at the urethral meatus opening..."</p> <p>Interview with CNT #2 on January 26, 2011, at 4:20 p.m., outside of the resident's room, confirmed the perineal/catheter care was not completed in a sanitary manner.</p>	F 315			

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